



2023-24 Belding – OK Conf
Pre-Participation Physical Exam Form

Medical Examination

THIS SIDE TO BE COMPLETED BY EXAMINING MEDICAL PROFESSIONAL

Name: _____ Date: _____

Ht: _____ Wt: _____ HR: _____ BP: _____ BP reek: _____
Corrective Lenses: Y or N Vision: R _____ L _____

Physical Exam	Normal	Abnormal
General Appearance		
HEENT		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
Spine		
Upper Extremity		
Lower Extremity		
Joint Specific (optional)		
Hernia (males only)		

COMMENTS	
General Medical	Musculoskeletal

RECOMMENDATIONS:

1. CLEARED WITHOUT RESTRICTIONS
2. Cleared for LIMITED PARTICIPATION (specify) _____

3. NOT CLEARED for participation (explanation) _____

4. Requires further evaluation before final recommendation _____

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above.

Printed Name: _____ Date: _____

Signature: _____ MD, DO, PA, or NP

A Current-Year Physical is one given on or after April 15 of the previous school year.



2023-24 Belding O.K. Conference
Pre-Participation Physical Exam Form

Emergency Information

School: _____

Name: _____ DOB: _____ Gender: M F Grade: _____

Parent/Legal Guardian Name(s): _____

Address: _____ Street _____ City _____ State _____ Zip _____

Phone #: Home: _____ Work: _____ Cell: _____

Emergency Contact(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Information:

Family Insurance Co.: _____ Phone: _____

Contract/Group #: _____ Policy #: _____

Parent/Legal Guardian Consent & Assumption of Risk:

Participation in interscholastic athletics requires an acceptance of risk of injury. These risks include, but are not limited to the following: death, quadriplegia, paraplegia, internal injury, closed head injury (possibly including post-concussion syndrome) and musculo-skeletal injuries (including sprains, strains, and fractures). Some of these injuries may result in medical treatment, surgery, and/or permanent disability. I understand that coaches, athletic trainers, and physicians (including side-line team physicians) will use their professional judgment when administering proper medical treatment. I have had the opportunity to ask questions, hereby recognize the risk of injury, and give my consent for my son/daughter to participate in interscholastic athletics. I further consent for the disclosure of information otherwise protected by FERPA and HIPPA for the purpose of determining eligibility for interscholastic athletics to the MHSAA, OK Conference, and school district. I also agree to accept and comply with all MHSAA, OK Conference, and school district athletic policies.

Parent/Legal Guardian Signature: _____ Date: _____

Student-Athlete Signature: _____ Date: _____

Authorization of Treatment:

I, _____ hereby give my permission for my son/daughter, _____ to undergo medical treatment for any injury or illness he/she may sustain or acquire while participating in interscholastic athletics. I understand that medical personnel, including athletic trainers and sideline team physicians, will perform only those procedures within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries or illnesses. In the event more serious medical treatment/procedures are required and I cannot be reached for my consent, I authorize any licensed medical practitioner to perform such treatments/procedures medically necessary to alleviate the problem.

Parent/Legal Guardian Signature: _____ Date: _____

This physical exam is NOT intended to replace Annual Well Child Exams by your family physician.

Medical History

1. Do you have any chronic or ongoing medical conditions?
If yes, explain: _____ Yes _____ No
2. Have you ever been hospitalized and/or had surgery for any reason?
If yes, explain: _____ Yes _____ No
3. Do you have any allergies (medications, insects, foods, etc.)?
If yes, explain: _____ Yes _____ No
4. Are you currently taking any medications or supplements (include over-the-counter)?
If yes, explain: _____ Yes _____ No
5. Have you had a medical problem or injury since your last physical exam?
If yes, explain: _____ Yes _____ No
6. Have you ever passed out or nearly passed out during or after exercise?
Have you ever had chest pain, tightness, or pressure during or after exercise?
Have you ever been dizzy or light headed during or after exercise?
Do you get more tired or short of breath than others during exercise?
Does your heart ever race or skip beats (irregular beats) during exercise?
Has a doctor ever ordered a test for your heart (e.g. ECG/EKG, echocardiogram)?
Have you ever been told you have any of the following (check all that apply):
 High blood pressure Heart murmur High cholesterol
 A heart infection Kawasaki disease Other: _____
 Explain ALL yes answers & checked items: _____
7. Has anyone in your family died suddenly or of heart problems before age 50?
Do anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
Has anyone in your family had unexplained fainting, seizures, or near drowning?
Does anyone in your family have any of the following cardiovascular conditions:
 Hypertrophic cardiomyopathy Marfan syndrome Brugada syndrome
 Arrhythmic right ventricular cardiomyopathy Long QT syndrome
 Catecholaminergic polymorphic ventricular tachycardia Short QT syndrome
 Explain ALL yes answers & checked items: _____
8. Have you ever had a concussion, head injury, or recurrent headaches?
If yes, explain: _____ Yes _____ No
 Have you ever been knocked out or unconscious?
If yes, explain: _____ Yes _____ No
 Do you have headaches with exercise?
If yes, explain: _____ Yes _____ No
 Have you ever had any of the following after a hit, blow to the head, or falling:
 Confusion Prolonged headache Inability to move your arms or legs
 Memory problems Numbness, tingling, or weakness in your arms or legs
 Explain ALL checked items (include dates): _____
 Have you ever had a stinger, burner, or pinched nerve?
If yes, explain: _____ Yes _____ No
 Have you ever had seizures, convulsions, or a history of epilepsy?
If yes, explain: _____ Yes _____ No

9. Have you ever become ill, dizzy, or passed out while exercising in the heat?
If yes, explain: _____ Yes _____ No
 Do you get frequent muscle or heat cramps when exercising?
If yes, explain: _____ Yes _____ No
 Do you or someone in your family have sickle cell trait or disease?
If yes, explain: _____ Yes _____ No
10. Do you or someone in your family have asthma or another obstructive lung disorder?
If yes, explain: _____ Yes _____ No
 Do you cough, wheeze, or have difficulty breathing during or after exercise?
If yes, explain: _____ Yes _____ No
 Have you ever used an inhaler or taken asthma medication?
If yes, explain: _____ Yes _____ No
11. Do you currently have, or have you EVER HAD any of the following:
 Hernia Mononucleosis Diabetes Kidney disease Scoliosis Absent spleen
 Explain ALL checked items (include dates): _____
12. Are you missing one of a set of paired organs (kidneys, eyes, ovaries, testes, etc.)?
If yes, explain: _____ Yes _____ No
13. Have you ever sprained, strained, dislocated, fractured, broken, experienced repeated swelling in, had a stress fracture in, or otherwise injured any bones or joints? (check all that apply)
 Head Neck Chest/ribs Back Shoulder Forearm Elbow Wrist
 Hip Thigh calf/shin Knee Ankle Foot/toes Hand/fingers
 Explain ALL checked answers (include dates): _____
14. Have you ever had a condition/injury that required x-rays, MRI, CT scan, or therapy?
If yes, explain: _____ Yes _____ No
15. Do you use any special equipment (braces, pads, mouthguards, neck rolls, etc.)?
If yes, explain: _____ Yes _____ No
16. Have you had any problems with your vision or injuries to your eyes?
Do you wear glasses, corrective lenses, or protective eyewear?
Explain ALL yes answers: _____ Yes _____ No
17. Have you ever had any skin problems (fashes, itching, MRSA, herpes, acne)?
If yes, explain: _____ Yes _____ No
18. Have you ever had an eating disorder or restricted food to lose weight?
Do you want to weigh MORE or LESS than you do now?
Do you feel stressed?
Explain ALL yes answers: _____ Yes _____ No
20. **FEMALES ONLY** Age at 1st menstrual period? _____ Date of most recent? _____
 Number of periods in the last 12 months? _____ Longest time between periods? _____
21. Has a doctor ever denied or restricted your participation in sports for any reason?
If yes, explain: _____ Yes _____ No

****I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.**
 Signature of Athlete: _____ Date: _____
 Signature of Parent/Guardian: _____ Date: _____